SIG Academic Subcommittee Notes
10-14-05

Present

- Mark DeKraai
- Todd Glover
- Ken Gallagher
- Richard Wiener
- Deb Anderson
- Teresa

On Phone

- Clifton Hogancamp

Introductions

Agenda

- The Academic Subcommittee does not include all research organizations such as UNK, Wesleyan, Creighton, Boys Town and Girls Town, Doane, etc.

- A website for the state of Oregon was provided that is doing a similar thing. They have a general broad form of evidence based research. It is really broad. It is a direction we could take. New York State has something similar too, but it is not as organized. Missouri has a lot of Integration too.

- A list of models to assess evidence-based practices was discussed organized by discipline. There are four main commonalities: Research, secondary data, Clinical experience, and other. We have 9 different disciplines in various areas. Randomized Control is at the top of the hierarchy of research. The divisions and criteria are very elaborate.

- The group discussed that a lay version of hierarchy of evidence based practice would be valuable and would benefit policy makers. The Depart of Ed version appeared to be user friendly.

- There is a potential problem if this hinders new emerging practices. Informed discussion of innovative practice has to take place to not hinder new practices. Some innovative approaches may not lend itself to these criteria. Some trials in the early stages need to be considered.

- Instead of finite practices list, this committee would have guidelines and someone would evaluate it. In practice (the real world) there would be a committee that would take our guidelines and evaluate best fit for programs and various disciplines. That committee would have to defend it. The model would need to be flexible and recognize the limitations of evidence-based practices.

- There is a lot of overlap between disciplines. It would be a dangerous thing to have one set of guidelines for everything.

- There would need to be policy discussions about the implications for being designated an evidence-based practice. Agencies like Medicaid would have to recognize these standards to provide an incentive. This could be beneficial to both adult behavior health and children's' health.

- Clear language will have to be used to define what is evidence based best practice and what is not. Outcome data will sometimes be the only thing out there and there may be nothing in the literature. The data may only fit a unique population, and that is why there is no national data. That is not evidence based practice then. It would not satisfy the definition. That is why we may consider promising practices in addition to the evidence based practices.

- Organizations will know that there is some flexibility and multiple paths, so the group without clinical trials but has case studies will be recognized.

- If we focus strictly on EBP, programs that are promising would have to do something to prove evidence basis. A hardline position would be that the committee would have to tell these promising practices that they are not evidence based and give them some ideas about how to be evidence-based.

- There are some evidence based programs that are ineffective too. It would be nice to have a separate infrastructure to sort out these programs. Some programs would be termed as just plain bad.

- Next steps: 1) develop a lay definition of evidence base and 2) look at other state approaches including the Oregon model.

- By December, we could develop guidelines but not start implementation.

- Next meeting: November 7th. Grant Evaluation, refined model for assessing evidence-based practices, and structures in other states will be discussed.